The Maternity and Infant Act of 1921, popularly known as the Sheppard-Towner Act, set the precedent for grants to the states for maternal and child health services under the Social Security Act and for the many subsequent types of grants for health purposes. In this paper, the origin, development, and fate of the Sheppard-Towner legislation are examined as a case study in federal-state partnerships.

THE SHEPPARD-TOWNER ERA: A PROTOTYPE CASE STUDY IN FEDERAL-STATE RELATIONSHIPS

Edward R. Schlesinger, M.D., M.P.H., F.A.P.H.A.

THE month of November, 1966, marked the 45th anniversary of the signature into law of the Sheppard-Towner Act for the Promotion of the Welfare of Maternity and Infancy. The Sheppard-Towner Act, as the first peacetime grant-in-aid program to the states for health purposes, broke new ground in federal-state relationships. From the time the first funds reached the states in May, 1922, until the program was officially declared dead and was supposedly decently buried in June, 1929, after a two-year extension beyond its original authorization, well *under* seven million dollars had actually been provided in grants-in-aid to the states, or less than one million dollars a year. By present-day standards, this was a trickle of funds, but it paved the way for the grant-in-aid programs for health purposes under the Social Security Act in the middle 1930's, the stream of new funds under various categorical disease programs of the 1940's and 1950's, and the current flood of funds for health purposes under specific health legislation and under legislation having broader objectives.

The Sheppard-Towner era was a prototype, in a small way, of the highly complicated and varied patterns in federal-state-local relationships of the present day. As Martha Eliot has said: "The Sheppard-Towner Act established the national policy that the people of the United States, through their federal government, share with the states and localities the responsibility for helping to provide community services that children need for a good start in life."[1]

It should prove timely and relevant to examine critically the circumstances surrounding the genesis and termination of the Sheppard-Towner Act, especially since so many of the arguments advanced in the controversy over the act have such a contemporary ring. I must acknowledge, at the outset, that the term Sheppard-Towner era is to a large extent a misnomer since the act and the activities of the federal government it engendered appear to have been so out of keeping with broad government policy of the period. Nevertheless, in the light of more recent developments, I think we are not too far off in referring to a Sheppard-Towner era.

Genesis of Sheppard-Towner Act

The Sheppard-Towner Act was the product of an essentially fortuitous combination of the courage and conviction

of a dedicated individual and the circumstances of the times. The dedicated individual was Julia C. Lathrop, then chief of the Children's Bureau, who had come to her conviction about the need for action to save the lives of mothers and infants from her earlier experiences at Hull House in the slums of Chicago. Under Miss Lathrop's direction, the Children's Bureau conducted a number of noteworthy investigations of infant mortality in communities throughout the country. Subsequent investigations of maternal mortality by Dr. Grace L. Meigs showed that maternal mortality in the United States, although in great measure preventable, was not decreasing. The 1916 annual report of the Children's Bureau gave the first public indication of Miss Lathrop's attitude. The report prophesied, "As soon as the public realizes the facts to which Dr. Meigs calls attention it doubtless will awake to action, and suitable provision for maternal and infant welfare will become a part of all plans for local protection of public health."[2]

Without further public preparation Miss Lathrop presented her radically new plan for grants-in-aid to the states for maternal and child health services in the Children's Bureau report for the following year.[3] She called for a nationwide program that would provide public health nurses for service and health instruction, instruction in schools and universities, and through different forms of extension teaching on hygiene for mothers and children, well child conference centers, adequate confinement care, and hospital facilities for mothers and children.

To accomplish these objectives in areas of greatest need, mostly in rural areas, she suggested that the federal government provide grants to the states for maternal and infant "protection," to be distributed in local areas where investigation showed the need, and where "contributions are duly authorized from state and county funds in such proportions to the federal fund as may be determined."[3] This proposal for matching grants-in-aid was not based on the precedent set by war-time control of venereal diseases under the Chamberlain-Kahn Act. She turned, instead, to ample precedents set in various programs far afield from health services. She pointed in particular to the Smith-Lever Act of 1914 which provided matching grants-in-aid for cooperative agricultural extension work between agricultural colleges in the several states.

What was the nature of the times in which this proposal first saw the light of day? At first glance it would seem that a more unpropitious time—a time of deepening American involvement in the First World War—could not have been chosen. The proposal, however, did not meet with any adverse reaction from the Wilson Administration. In point of fact, it was consonant with the administration's effort to protect the health and strength of the civilian population in a time of war. An extension of this concern was the campaign conducted by the Children's Bureau in 1918, with President Wilson's approval, to arouse the nation to the importance of conserving childhood in times of national peril. In this "Children's Year" campaign women's groups and individual women in large numbers were involved actively in measures to promote the health of children. It is evident, then, that the proposed legislation for the protection of maternity and infancy arrived on the scene when a major thrust of the administration in power, to use present-day jargon, was in the direction of broad health and welfare concerns.

Passage of Act

Julia Lathrop then embarked on what Jessie Bierman has called a policy of active advocacy to attain what she was convinced was a highly desirable goal.[4] She enlisted support for her measure wherever she could. Fortuitously her proposal was very attractive to the

women's groups whose voices were being heeded with increasing attention as the states fell in line behind the Nineteenth Amendment to the Constitution which extended the vote to women. The support of women's organizations (and of individuals and organizations interested in the health and welfare of children) was forthcoming in a campaign that was well organized from the start; the campaign was not identified in any way with the militant women's groups in the suffragette movement which had initiated and carried on the fight for women's suffrage.

Miss Lathrop's proposal was introduced into Congress in 1918 by Jeanette Rankin, the first woman member of Congress. Over the succeeding three years amended versions of the bill received increasing support until the final version was embodied in the successful Sheppard-Towner Act of 1921. At hearings on the bill before the House in 1920 Miss Lathrop took full responsibility for the legislation even though she was, as she said, "well aware of the fact that it is not popular for bureaus to create new activities for themselves, or ask for measures increasing their own powers." She went on to say that she had reviewed the history of Children's Bureau investigations of maternal and infant mortality. In her words, "as we considered the meanings of the reports and statistics secured in the bureau's investigation we felt that it was not for us to say we had done enough when we had written pamphlets and had them printed and bound and sent out to libraries for preservation, while the vast body of taxpayers never knew of their existence nor of the facts as to human life which they set forth in costly tabulations."[5]

The list of organizations and prominent individuals favoring passage of the Sheppard-Towner Bill at congressional hearings was most impressive.[6] In addition to such organizations as the American Child Hygiene Association and the National Conference of Catholic Charities, a broad range of women's organizations, including the General Federation of Women's Clubs, the National Women's Christian Temperance Union, and the Continental Congress of the Daughters of the American Revolution, provided unquestioning support. Nonpartisan support came from both the Women's National Republican Executive Committee and the National Democratic Committee.

The Sheppard-Towner Act was also fortunate in its opposition. The shrill voices of the Medical Reference Bureau and the American Medical Liberty League, both ultraconservative organizations, of antivivisection groups, and of women's organizations opposed to women's suffrage drowned out more reasonable voices expressing specific objections to the bill.

The American Medical Association expressed its opposition editorially in its Journal,[7] but did not appear formally at the hearings. The American Medical Association objected to the bill in relatively mild terms on grounds that the legislation was economically unsound, that the federal government was invading state and local functions, that no emergency in maternal mortality existed as claimed, that the proposed program was not an effective remedy for existing conditions and, "most important," that the proposed program, if it were to be enacted, should be in the Public Health Service, not in the Department of Labor.

By the presidential campaign of 1920 support for the measure had become overwhelming. The Democratic platform came out in outright support for the bill. Support in the Republican platform was stated in more general terms, but Warren G. Harding, as the Republican standard bearer, committed himself firmly to the measure during the campaign.[8]

In his first State of the Union Message to Congress President Harding kept his campaign commitments in support of the Sheppard-Towner Bill. He stated, "I as-

sume the maternity bill, already strongly approved, will be enacted promptly, thus adding to our manifestation of human interest."[9] This support for a program involving increased federal expenditures appeared out of keeping with the rest of the message. Harding placed major emphasis in his message on domestic problems, stating that he knew of "no more pressing problem at home than to restrict our national expenditures within the limits of our national income." Despite this apparent inconsistency, the Harding Administration continued its firm support of the Sheppard-Towner Act after its passage, even when its constitutionality was being strongly contested up to the Supreme Court.

Discontinuance of Act

We are not now concerned with the accomplishments of the programs promoted and partially supported under Sheppard-Towner appropriations. Suffice it to say that by 1927, 45 states and the Territory of Hawaii had accepted the provisions of the bill; Massachusetts, Connecticut, and Illinois were the only hold-outs.[10] The momentum of the program carried along after the cessation of federal grants-in-aid until the effects of the depression forced curtailment of state expenditures. In 1929, 15 states and Hawaii appropriated funds equal in amount to the combined state and federal funds of the previous year. In 14 other states increased state appropriations were made, but these were not equal to the combined total of the previous federal and state appropriations under the program.

Given such a high degree of acceptance of the program throughout the country, why was the Sheppard-Towner legislation extended for only two years in 1927 and allowed to lapse in 1929? It must be recalled that this was radically new legislation in the health field, a fragile seed growing in isolation from the then traditional health programs. While the seed took root and grew when environmental circumstances were highly favorable, it was readily destroyed (or so it seemed) when only a moderate change in the environment occurred.

The first change, which I cannot document specifically from the record, was the diminution in influence of the major forces supporting the legislation. Woman suffrage had been in effect for two presidential elections and innumerable state and local elections. It had become apparent that there was no such thing as a women's vote per se; women voted basically according to the same issues as the men. Whatever fear had existed of a solid bloc of women voters had been fully dissipated by 1927. In addition, it was too much to expect that the enthusiasm and activity of the groups supporting the Sheppard-Towner Act during its parlous course to passage and its early years in operation could be maintained at a high pitch indefinitely.

At the same time opposition to the program became more organized and outspoken. Even after the passage of the Sheppard-Towner Act the American Medical Association was relatively mild in its opposition. The association had accepted passage of the Sheppard-Towner Act as inevitable, "as a political necessity and a redemption of party pledges."[11] Late in 1922 the Journal of the American Medical Association published a detailed discussion of the Sheppard-Towner Act by a member of the Children's Bureau staff.[12] But by 1926 the association had changed to a position of outright opposition and to active mobilization of the country's physicians and other groups against its continuation.[13]

The shift in the balance of these two forces in the general climate of the times was enough to prevent legislative action for continuance of the Sheppard-Towner Act, even though there was still powerful congressional support for the program. Federal grants to the states for health

services were totally alien to the broad policies of the Coolidge Administration, but President Coolidge did not come out in outright opposition to the program. His budget message to Congress late in 1926, while calling for funds to support the grant-in-aid program for two years, used the Maternity and Infancy Act as an opportunity to expound his views on federal-state relationships.[14]

"I have referred in previous budget messages," the President said, "to the advisability of restricting and curtailing federal subsidies to the states. The maternity act offers concrete opportunity to begin this program. The states should now be in a position to walk alone along this highway of helpful endeavor, and I believe it is in the interest of the states and the federal government to give them the opportunity."

President Coolidge's attitude must undoubtedly have been reinforced by New England's opposition to the program. Three of the New England States were among the last five to take advantage of the Sheppard-Towner grants-in-aid. Massachusetts and Connecticut remained outside the fold altogether in the sole company of Illinois, and Massachusetts had taken the lead in challenging the constitutionality of the Sheppard-Towner Act in the courts.

The low esteem to which the Sheppard-Towner Act had fallen in administration circles was clearly exemplified in President Hoover's failure to mention the program in his public announcement of the choice of United States delegates to the Fifth English-Speaking Conference on Maternity and Child Welfare in London.[15] The announcement was made only a few months before the scheduled lapsing of the Sheppard-Towner Act on June 30, 1929. The appointment of a staff member of the Public Health Service rather than of the Children's Bureau as a delegate to the conference should also be noted. Furthermore, in his proclamation on Child Health Day a week earlier President Hoover also made no reference to Sheppard-Towner.[16] These actions (or absence of action) took on added significance in view of Hoover's known long-time concern for the welfare of children.

Arguments About Sheppard-Towner Act

Many of the arguments in the controversy around the Sheppard-Towner Act, as previously indicated, have a contemporary ring. While it is hazardous to strain historical parallels, the realization that present-day controversies are not necessarily original with us is helpful in providing some perspective on the current scene.

A perennial argument was the need for economy, even though the amount of funds requested was minuscule by present-day standards. As Mustard pointed out, the amounts proposed in 1918 "amazed the seasoned and perhaps smug male public health administrators of that day."[17] The expenditure of federal funds was justified (as is often done today in other connections) by comparing the proposed amount with the much larger amounts already made for animal health and agricultural education.[8]

The need to use health manpower at its highest levels of competence is a burning contemporary issue. Miss Lathrop phrased this problem in economic terms rather than in shortages of health personnel: "The education of a doctor is so costly—and is growing more costly all the time—and we need him so much for research into those diseases whose causes he has not yet discovered that we cannot afford to send him doing errands which a social worker or nurse, or anyone else can do."[5]

The earliest version of the legislation would have required a separate board of maternity and infancy, of specified composition, in each state. The implications such a precedent would have had for later programs are obvious. The Ameri-

can Public Health Association and prominent individuals in public health were successful in having a substitute provision in the legislation as finally passed which required that the regular state health unit be designated as the administering agency if a maternal and child health unit existed within it.

Just as today, unfavorable comparisons were made between the rate of infant mortality in the United States and the rates in some other countries, especially with countries such as New Zealand, which had well-established maternal and child health services.

Objections were raised to the specialized nature of the health services in the localities to be financed under the Sheppard-Towner Act. A number of the Executive Committee of the Conference of State Health Officers favored amending the proposed legislation to permit states and localities to use the money in any way suited to local conditions as, for example, in the development of a safe water supply, and without regard to any standards or limitations promulgated by the Children's Bureau.[6] The number of categorical health programs would increase geometrically over the years before serious steps in the direction of this recommendation would be taken.

Designation of the agency in the federal government to administer the Sheppard-Towner program was a major source of controversy. Established health agencies and professional organizations of public health personnel favored placing the proposed program under the Public Health Service, as the regular federal health agency dealing with states, and to avoid duplication of services and unbalance in the rural health program.[8] The Children's Bureau countered these arguments with its contention that the proposed program went far beyond medical care in its more limited sense, and that poverty, ignorance, and other social factors had an important bearing on maternal and infant mortality. The Report of the House Committee on Labor, in approving the 1918 version of the legislation, quoted a Public Health Service statement about the difficulty of incorporating prenatal care in rural health work, in contrast to control of contagious diseases, as indicating lack of interest of the Public Health Service in maternal health work.[18] The question was finally resolved in favor of the Children's Bureau at a conference of the respective Cabinet chiefs, with a Board of Maternity and Infant Hygiene, of which the Surgeon General of the Public Health Service was to be a member in an advisory capacity.

The constitutionality of the Sheppard-Towner Act was challenged in the courts by Massachusetts chiefly on the ground of federal invasion of the powers and rights of the states. The Supreme Court responded that, by the mere enactment of the statute, nothing had been done without the consent of the states. The Supreme Court did not actually rule on the constitutionality of the act.

I cannot refrain from quoting a prophecy of doom offered by the attorney general of Massachusetts in his brief before the Supreme Court in 1922: "so-called 'Federal Aid' legislation by Congress, by which appropriations are made by Congress for local and not national purposes, to States which accept the federal grants, has been found to be an effective way to induce States to yield a portion of their sovereign rights, that bills of a similar nature calling for expenditures of immense sums of money . . . are now pending or proposed, and that unless checked by this Court on the ground of unconstitutionality no limit can be foreseen to the amounts which may thus be expended for matters of local concern, resulting in the establishment of large federal bureaus with many officers for the performance of duties outside the purview of the Constitution."[19] Apart from the pejorative statement about the purview of the Constitution this prophecy has been fulfilled beyond any

expectations of the early 1920's. The nation has somehow survived the catastrophe.

The idea of federal grants-in-aid for maternal and child purposes did not die with lapsing of the Sheppard-Towner Act, only to emerge, phoenix-like, from its ashes in the Social Security Act six years later. On the contrary, activity looking to restoration of the program was continuous in every session of Congress after 1928. One version, presaging the provisions of Titles V and VI of the original Social Security Act, in its support of maternal and infant care programs under the Children's Bureau and general health program support under the Public Health Service, actually passed the House in 1931. When the Roosevelt Administration turned to consideration of a broad program of social security, it was almost a foregone conclusion that provision would be made for federal grants-in-aid for maternal and child health and general health purposes. What has happened since 1936 is no longer prologue.

In conclusion, it might be more appropriate to refer to the past decade or two as the Sheppard-Towner era, rather than the 1920's. The Sheppard-Towner Act was clearly in advance of its time. Its seed was planted by a courageous individual; it was nurtured in the soil of wartime concern for the well-being of the civilian population; it grew in the favorable climate of the movement for women's rights; it flowered under the political impact of universal suffrage; and it withered, as a solitary plant often does, when the political and social climate changed. But the roots were sturdy and, when the environment was again favorable, it sprang into full bloom. This time, for better or worse according to one's viewpoint, it scattered its seeds to the four winds and the seeds took root in a fertile soil. There is no need to belabor further the significance of the Sheppard-Towner Act for today.

ACKNOWLEDGMENTS: I would like to express my gratitude to Martha M. Eliot and Katharine F. Lenroot for contributing their knowledge of the Sheppard-Towner situation. It is of course understood that any interpretations given in this paper are entirely my own responsibility. I would also like to thank the staff of the Children's Bureau for making their historical files freely available to me.

REFERENCES

1. Eliot, M. M. The Children's Bureau: Fifty Years of Public Responsibility for Action in Behalf of Children. A.J.P.H. 52,4:576, 1962.
2. Children's Bureau Annual Report for 1916, Washington.
3. Children's Bureau Annual Report for 1917, Washington.
4. Bierman, J. M. Advocacy and Inquiry: Their Roles in Development of Health Services for Mothers and Children. A.J.P.H. 56,5:720, 1966.
5. Hearings on HR 10925, Public Protection of Maternity and Infancy, House Committee on Interstate and Foreign Commerce, Dec. 20-29, 1920. Washington, D. C.: Gov. Ptg. Office, 1921.
6. Hearings on HR 2366, Public Protection of Maternity and Infancy, House Committee on Interstate and Foreign Commerce, July 12-23, 1921. Washington, D. C.: Gov. Ptg. Office, 1921.
7. The Sheppard-Towner Bill. Editorial. J.A.M.A. 76: 1503 (May 28), 1921.
8. Leigh, R. D. Federal Health Administration in the United States. New York, N. Y.: Harper, 1927.
9. Harding's Message to Congress of April 12, 1921. New York Times (Apr. 13), 1921.
10. Children's Bureau Annual Report for 1929, Washington.
11. The Sheppard-Towner Bill—Public Health or Politics? Editorial. J.A.M.A. 78:435 (Feb. 11), 1922.
12. Rude, A. E. The Sheppard-Towner Act in Relation to Public Health. Ibid. 79:959 (Sept. 16), 1922.
13. The Attempt to Perpetuate the Sheppard-Towner Act. Editorial. Ibid. 91:1721 (Dec. 1), 1928.
14. President Coolidge's Budget Message to Congress. New York Times (Dec. 9), 1926.
15. New York Times (Apr. 6), 1929.
16. New York Times (Mar. 27), 1929.
17. Mustard, H. S. Government in Public Health. New York, N. Y.: Commonwealth Fund, 1945.
18. Report of the House Committee on Labor on HR 12634. Washington, D. C.: Gov. Ptg. Office, 1918.
19. Brief for the Plaintiff, No. 24, Original, Commonwealth of Massachusetts, Plaintiff. Supreme Court of the United States, October Term, 1922.

Dr. Schlesinger is professor and head of the Maternal and Child Health Program, University of Pittsburgh Graduate School of Public Health, Pittsburgh, Pa. 15213.

This paper was presented before the Maternal and Child Health Section of the American Public Health Association at a Special Session at the Ninety-Fourth Annual Meeting in San Francisco, Calif., October 31, 1966.